

Responses to Question from the Appropriations Committee Informational Hearing with the Department of Social Services - June 22, 2020

- 1. Update on initiatives/costs that will be funded solely by federal dollars and those that require state expenditures. Are there areas where you anticipate the cost to shift to the state in FY 21?*

The Department has been working closely with the Office and Policy and Management regarding funding for all COVID related expenditures. As a result, there are approximately 30 specific COVID-related items with financial impacts that either have been implemented or are in progress with a total funding impact of \$245 million. Off this amount, approximately \$184 million is anticipated to be supported with federal Coronavirus Relief Fund (CRF), approximately \$29 million with State funds, and approximately \$32 million from federal Medicaid support.

The initiatives are targeted in nature for the duration of the COVID emergency, with many of the provider relief initiatives funded through CRF. The CRF can be used through December 30, 2020. The potential for cost shifts to the State in SFY 2021 is still under review as part of the ongoing COVID response coordination, and the broader General Fund budget review process. Outside of these targeted COVID interventions, additional requirements may result due to the economic impact of the pandemic and the potential impact on caseloads as discussed in the questions related to enrollment below. The extent of that impact is difficult to know with a high degree of confidence given the wide range of uncertainty at the present time.

For assistance in identifying the many COVID response actions taken with fiscal implications, we are attaching the COVID financial impact tracking file maintained by the Office of Policy and Management, and published in their monthly letter to the Comptroller. This document is also helpful in sorting through the various actions taken and their respective impacts in SFY 2020 and SFY 2021.

- 2. Recent increase in HUSKY enrollment. Are individuals who would have been up for redetermination and are being automatically continued included in those figures?*

Yes, individuals who would have been up for redetermination are included in all counts of enrollment. For any given month, there will generally be discontinuances for a variety of reasons, offset by new enrollments, resulting in a net change for the month. When the decision was made to suspend discontinuances, the Department projected the impact of that continued eligibility. Currently, we estimate that 15% of renewals, or close to 5,000 clients per month, who would have otherwise been discontinued per month, continue to receive benefits. This accounts for a sizable portion of the net new enrollment we have seen over the COVID period.

- 3. Given the suspension of eligibility redeterminations, what will redetermination process for these individuals look like? What will it mean for FY 21 enrollment and costs?*

- In order to ensure continuity of vital benefits and balance operational needs, and pursuant to authority provided in Executive Order 7i, we initially pushed out medical and cash assistance renewal end dates by 3 months for individuals who were scheduled to have their renewals completed by the end of March, April, and May respectively. Thus the March end dates became June end dates, April became July, and May became August.

- Pursuant to federal authorization, SNAP renewal end dates have been pushed out 6 months for individuals who were scheduled to have their renewals completed by the end of March, April, May and June, respectively. Thus the March end dates became September end dates, April became October, May became November, and June became December.
- Pursuant to federal authorization, SNAP periodic review forms (PRFs) were waived for the months of March-June, and will restart in July.
- As a result of these actions, the volume of renewals will generally be double for the remainder of the calendar year.
- We restarted the renewal process for medical and cash cases with June end dates (which also included the pushed-out March end dates, so a double-volume month from an operational perspective).
- The renewal process for SNAP cases will start again for individuals with a July end date.
- The medical renewal process is the same as usual, with eligibility being evaluated “passively” for those individuals with eligibility data that falls within standards based on automated database checks, and forms being sent out to those for whom the “passive” review process was unable to confirm eligibility. Those forms have to be returned and processed. If a form is returned in time but unable to be processed for some reason, the individual’s eligibility will be continued until the individual is determined eligible or ineligible.
- The cash renewal process is also largely the same as usual, with forms being sent to individuals for completion. If a form is returned in time but unable to be processed for some reason, the individual’s eligibility will be continued until the individual is determined eligible or ineligible. One change is that no face-to-face interviews are required.
- Any client who we have been able to affirmatively determine eligible for ongoing eligibility has been granted their standard certification period – i.e., generally another year of benefits.
- For medical clients whom we have not been able to affirmatively determine eligible for a full benefit period, we will prevent them from closing off benefits for the duration of the federally-declared public health emergency (at this time, we are projecting the emergency to go into at least July, so no cases will close at the end of June). This continuity of benefits is required in order to claim the enhanced FMAP. The only exceptions to this non-closure approach are for clients who have deceased, moved out of state, or requested closure; those cases will close.
- For cash clients whom we have not been able to affirmatively determine eligible for ongoing eligibility, we prevented their closure up through the end of June. At this time, however, due to budget concerns we will begin terminating benefits for clients who have not returned renewal documents or have otherwise not been affirmatively determined eligible for ongoing cash benefits.

- Impact on 2021 enrollment

- The Department, along with the Office of Policy and Management, is closely monitoring the unemployment claims data issued by DOL and enrollment data
- To date over 400,000 unemployment claims have been received since March 1st.
- The impact on Medicaid enrollment has not yet been seen – most other states have cited a similar experience to date
- We may see an impact upon expiration of the \$600/week unemployment benefit add-on on July 31st
- If 20% of the individuals requiring UC benefits over the past few months move on to Medicaid at the rate of 20% of all individuals affected, the impact could be as high as 80,000 initially
- The extent of the impact will be closely correlated to the economic recovery

4. *How long do you anticipate being able to provide uninsured persons (Citizens and Non-Citizens) with coverage for COVID-19?*

- We anticipate being able to provide coverage for the limited benefit of COVID-19 testing and a provider visit that led to a COVID-19 test for the duration of the federally-declared public health emergency.
- The public health emergency can only be in effect for 90 days at a time (see <https://www.phe.gov/Preparedness/legal/Pages/phedeclaration.aspx>). The most recent extension of the declared emergency runs through July 25, 2020. In order to continue offering Medicaid benefits beyond that date, the emergency will need to be extended again.

Once the public health emergency expires, further coverage for testing will be without direct federal support. You may be aware of the significant testing activities that are occurring through the statewide effort, currently funded through CRF. All testing options will need to be fully reviewed in the context of available funding, the ongoing extent of the pandemic, and the expert advice of public health officials.

5. *Are there particular providers or a group of providers who are struggling and are not eligible for COVID relief funds?*

Many Connecticut health care providers have received significant financial assistance through the federal CARES Act Provider Relief Fund, which is being distributed by the Health Resources and Services Administration (HRSA) under the umbrella of the federal Health and Human Services Administration. Initially, this focused exclusively on providers that bill Medicare, but recently HHS has targeted a tranche of funds for Medicaid providers. Please see more background on this. As the federal government has rolled out successive targeted distributions of these funds, the state has carefully examined the provider landscape to determine how best to address urgent needs, often in

advance of final information on the amount and extent of the distribution of PRF funds. These interim measures include actions such as:

- issuing financial advances to Connecticut health centers, to address their inability to perform any dental procedures during the public health emergency;
- COVID Relief Fund grants to all Connecticut nursing homes, approximating the value of a 10% rate increase for April 2020 on the rates in effect on July 1, 2019, and the value of a 20% rate increase for May and June 2020 on the rates in effect on July 1, 2019, adjusted for the projected impact of Medicare billings for a portion of COVID-positive patients;
- COVID Relief Fund grants to Connecticut nursing homes with demonstrated hardship costs above the various forms of relief provided at the state and federal level
- residential care homes (RCH) and Intermediate Care Facilities for individuals with intellectual disabilities (an average of 10% rate increase); and
- COVID Relief Fund grants to home health, home care and waiver providers (pending finalization).
- CRF distributions to chronic disease hospitals and certain behavioral health providers
- Medicaid 20% DRG add-on for COVID specific DRGs

The Department will continue to examine need for further intervention following distribution of the Medicaid tranche that is in process of being accessed by providers.

Overview of CARES Act Provider Relief Fund Distributions

Initially, two distributions of \$30 and \$20 billion centered on providers that bill for Medicare fee-for-service (e.g. hospitals).

Additionally, the following targeted distributions have been, or in the process of being, made.

Targeted Distribution	Total Amount	Recipients
High-Impact Distribution	\$12 billion	395 hospitals in high-impact areas
Rural Distribution	\$10 billion	Almost 4,000 rural health care providers
Allocation for Skilled Nursing Facilities (SNFs)	\$4.9 billion	Over 13,000 skilled nursing facilities
Allocation for Tribal Hospitals, Clinics, and Urban Health Centers	\$500 million	Around 300 Tribal Hospitals, Clinics, and Urban Health Centers
Medicaid and CHIP Distribution	~\$15 billion	Providers who bill for Medicaid and CHIP and did not receive General Distribution funds
Allocation for Safety Net Hospitals	\$10 billion	Eligible safety net hospitals

Here are more details on the Medicaid and CHIP distribution, as well as the allocation for safety net hospitals:

- Medicaid award:
 - **Total Amount:** \$15 billion for Medicaid providers
 - **Eligibility:** Any provider that did NOT receive a funding award from the first \$50 billion in awards made to providers with some level of Medicare utilization, and directly billed a state Medicaid program or Medicaid managed care plan between January 1, 2018 and May 31, 2020.
 - **Process:** Providers submit annual patient revenue information to HHS's provider relief fund portal.
 - **Award Amounts:** Minimum of two percent of gross patient care revenues, with final amount determined by provider-submitted data including number of Medicaid patients served.
- Allocation for safety net hospitals:
 - These hospitals will receive a minimum award of \$5 million and a maximum of \$50 million if they meet the following criteria:
 - A Medicare Disproportionate Payment Percentage (DPP) of 20.2 percent or greater;
 - Average Uncompensated Care per bed of \$25,000 or more. For example, a hospital with 100 beds would need to provide \$2,500,000 in Uncompensated Care in a year to meet this requirement;
 - Profitability of 3 percent or less, as reported to CMS in its most recently filed Cost Report.

For much more information on the overall amount of distributions, timeline and how the funds have been targeted, see here:

<https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html>

6. *Once the agreements are in place, are you prepared to test both patients and staff at nursing homes/facilities? How frequently and for how long?*

The current plan targets testing of all staff and patients, with adjustments for homes that have already completed testing to date. The State will be covering all costs under the Coronavirus Relief Fund through August 31st.

Testing will occur once per week, however, testing will be suspended for all nursing homes that are fully tested and have no evidence of COVID for both patients and staff. It is estimated that 30% of the homes will hit this benchmark every two weeks over the testing period.

Questions Raised During the Informational Hearing

7. The status of the 1915i State Plan Amendment.

The Department is at an advanced point of our informal discussions with CMS on the terms of the 1915i State Plan Amendment for the Connecticut Housing Engagement and Support Services (CHESS) Initiative. This SPA would be in consideration of moving CHESS as rapidly as possible to try to align with the housing and support needs of people who have experienced homelessness and who are presently being housed in hotels during the public health emergency. The SPA should be ready for review and submission in the next several weeks.

8. ABI Waiver - have there been any issues with either waiver or any problems reported for the number of workers working with this population?

The Department is not aware of any issues or received any reports regarding staffing for these programs.

9. Summary and formula for areas where providers, home health, home care and waiver services have received distributions.

Attached is a summary of various provider relief actions implemented or in process. Immediately below is a summary of the process being used for general provider group grants.

Process for General Coronavirus Relief Fund (CRF) Grant Payments for Providers

Executive Order

- The Department is working with the Governor's Office to extend Executive Order authority for the use of Coronavirus Relief Funds to provide financial support to additional providers.

Grant Funding Levels and Distribution

- Grant levels have been determined based upon the determined relief percentage which has been applied to 2019 Medicaid payments to designated provider groups
- The last six months of calendar year 2019 are generally used for the determination of the above overall grant distribution level
- Grant distribution by provider are based upon each provider's share of the total payments for the most recent full quarter, January 1, 2020 through March 31, 2020, to recognize the most current applicable distribution data

Grant Agreements and Payment Processing

- Distinct CRF grant agreements will need to be executed by all providers receiving CRF funding
- Providers receiving funds under the Payment Protection Program will be ineligible for CRF grant distributions
- Funding can only be used for documented COVID-related costs, and do not cover revenue losses
- Providers will access grant agreements through a dedicated provider portal and will submit executed agreements through that portal

- Upon receipt of the executed grant agreements, payments will be made to the provider for the full grant distribution

10. SNAP online purchasing – Is data available regarding how often it is being used?

The USDA - Federal Food and Nutrition Services (FNS) prohibits the release of this data. FNS states that there are too few retailers operating online to share even aggregated redemptions (or transaction counts) at the State level. Doing so would run afoul of prohibitions on releasing redemption data.

11. Distribution of the FQHC dental advances.

FQHC Dental Advances		
Billing Provider Name	Monthly Advance	Total Apr-Jun Advance
OPTIMUS HEALTH CARE INC	\$115,572.00	\$346,716.00
GENERATIONS FAMILY HEALTH CENTER, INC.	\$97,507.00	\$292,521.00
CORNELL SCOTT-HILL HEALTH CORPORATION	\$121,348.00	\$364,044.00
STAYWELL HEALTH CENTER, INC	\$228,752.00	\$686,256.00
CHARTER OAK HEALTH CENTER INC	\$70,685.00	\$212,055.00
COMMUNITY HEALTH SERVICES INC	\$93,358.00	\$280,074.00
SOUTHWEST COMMUNITY HEALTH CENTER INC	\$124,813.00	\$374,439.00
FIRST CHOICE HEALTH CENTERS, INC.	\$123,580.00	\$370,740.00
COMMUNITY HEALTH CENTER INC	\$754,069.00	\$2,262,207.00
FAIR HAVEN COMMUNITY HEALTH CLINIC, INC.	\$71,999.00	\$215,997.00
CONNECTICUT INSTITUTE FOR COMMUNITIES, INC.	\$10,609.00	\$31,827.00
WHEELER CLINIC INC,	\$23,966.00	\$71,898.00
NORWALK COMMUNITY HEALTHCENTER	\$12,054.00	\$36,162.00
FAMILY CENTERS INC.	\$5,959.00	\$17,877.00
Total	\$1,854,271.00	\$5,562,813.00